

I have examined also the records of cases treated at the Cornell Dispensary since its foundation five years ago. There have been in the General Medicine Clinic alone 13,500 cases, with only one of gastric ulcer—a male, a metal polisher, forty-nine years of age. He had had gastric symptoms for eight months, including hæmatemesis. I was greatly surprised by these data, the more so because Dr. William Armstrong, of my staff, has for several years devoted his time to making analyses of stomach contents as an aid to diagnosis. He reports that among 150 cases lately studied he has not once been enabled to make the diagnosis of gastric ulcer.

These data are of interest in showing the relative frequency of occurrence of gastric ulcer among certain classes of the community.

FINAL NOTE ON CASE II. OF ANGIONEUROTIC ŒDEMA.

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(From the Clinic of Internal Medicine, Dr. Dock.)

IN the November number of this JOURNAL for 1904 report was made of two cases of angioneurotic œdema, the second of which was the more important, inasmuch as it was possible to demonstrate a simple, non-inflammatory œdema in a bit of the gastric mucosa, which had been obtained by the stomach tube during lavage after a test breakfast, just at the onset of an attack of nausea, vomiting, and pain. The occurrence of exitus in this case is worth recording, as it resulted from a characteristic, though somewhat infrequent cause.

For the sake of convenience the more salient points in the patient's history may be recalled. The patient, a male, was twenty-one years of age in the fall of 1903, when he was admitted to the University Hospital because of swellings of the hands, legs, and larynx, and "stomach trouble." The mother of the patient has transient swellings of the hands, and one sister suffers from œdema of the face after trauma. Otherwise the family history is negative. The patient had "mumps," "measles," and "chicken-pox" in childhood, with good recovery in each instance. He first noticed a swelling in the hands when he was twelve years old. It usually disappeared within forty-eight hours. Later, swellings appeared in the feet, knees, and elbows, the scrotum and penis. At the age of seventeen the patient had "scarlet fever" with "nephritis," and at the same time he had an attack of "œdema of the glottis," for which tracheotomy was performed. He was unconscious at this time. He was

confined to bed for three weeks after the operation, during which time he says his temperature once reached 106°. It was about two months before the tracheotomy wound healed; previous to its healing there was a discharge, with a "fierce" odor, from the wound. His throat at this time was so sore that he could eat no solid food. After recovering from this illness the patient was in fairly good condition, except for occasional swellings, until April of 1903, when he had another attack of œdema of the larynx. This came on in the morning. At noon he was unable to eat any dinner, and at 6 P.M. of the same day he was unconscious. A second tracheotomy was performed. On July 13, 1903, the patient noticed a swelling "under the shoulder-blade" on rising in the morning. He was aware of swelling in the throat about 4 P.M. After supper he gradually became worse until midnight, when intubation was tried. This failed, and a trocar was thrust into the trachea. The patient was confined to bed five days at this time. About the middle of August he again had symptoms of œdema of the larynx, which subsided with steaming. Dr. Dock examined his larynx October 24, 1903, and dictated the following note: Larynx is small; epiglottis straight, but curled from side to side. Interarytenoid space deep. Entire mucous membrane red and slightly swollen. False vocal cords project inwardly, almost covering the true cords in phonation. Cords slightly red. Trachea small, moderately congested. Neck shows a scar about 3 cm. long, the width varying from $\frac{1}{4}$ to $1\frac{1}{4}$ cm.; skin pinkish over it. On swallowing, the lower half of the scar moves upward, being attached to the structures beneath. While in the medical clinic the patient's voice was husky, so that he could not speak above a loud whisper; he had transient swellings in the extremities, and an attack of nausea, pain, and vomiting, alluded to previously.

Since leaving the hospital the patient has been under the care of Dr. Floyd H. Randall, to whom I am indebted for the notes on his subsequent condition. Since the autumn of 1903 the patient has had two attacks of œdema of the larynx, the second of which proved fatal. The first occurred on July 15, 1904. Dr. Randall was called about 10.30 P.M., and found the patient extremely dyspnoëic and somewhat cyanotic; he inspired with great difficulty. A hypodermic injection of one-quarter of a grain of morphine was given; he was gradually relieved after about three hours. Because of the patient's distress, examination of the larynx was not possible. The swellings on other parts of the body, especially after blows, were very frequent, more so during the last few months, the patient's father thinks. The fatal attack occurred January 3, 1905. It must have come on very acutely, for the patient was apparently as well as usual when the family retired for the night. About midnight the parents were aroused by an unusual noise, and going to the patient's room found him propped up in bed, the front of

FIG. 1



Photograph of fresh preparation showing larynx and neighboring tissues and organs from Case II. of angioneurotic œdema. Extreme œdema.

FIG. 2



Photograph of fresh preparation showing larynx and neighboring tissues and organs from Case II. of angioneurotic œdema. Extreme œdema.

his night-shirt covered with blood. Dr. Randall was summoned at once, but exitus had already occurred when he arrived.

Before going on to a consideration of the autopsy findings, it may be well to include the additional valuable points in the family history furnished by Dr. Randall. He tells me that another child of the patient's mother "choked to death" very suddenly when about two weeks old. During the past few months, and especially since the death of the patient, the mother has shown more numerous evidences of angioneurotic œdema, from which she has suffered more or less since childhood. She has never had any throat symptoms.

FIG. 3



Photograph of fresh preparation showing larynx and neighboring tissues and organs from Case II. of angioneurotic œdema. Extreme œdema.

The swellings have been noticed on the limbs and face. Of late her neck has been inclined to swell.

Autopsy was performed on the patient some hours after death. Permission was obtained to examine only the respiratory tract. The mouth and pharynx were filled with blood. The sternum was removed; the lungs showed no special change. The walls of the pharynx, the tongue, larynx, trachea, and upper part of the œsophagus were removed *en masse*. The larynx presented a most extreme grade of œdema, which involved the epiglottis, the aryteno-epiglottidean folds, and the false and true vocal cords, the ventricle

being obliterated; in fact, there was the most intense œdema of all the loose laryngeal tissues above the true cords. Below the latter there was no evidence of œdema. The tissue at either side of the arytenoepiglottidean folds was also markedly œdematous. It is an interesting fact that no trace of scar from the tracheotomy wounds can be found in the trachea. The accompanying photographs, taken from the fresh specimen by Dr. C. H. Baker, illustrate beautifully the condition found.

In concluding this brief note I wish to express my thanks to Dr. Dock for his kindness in placing the specimen, which was sent to him, at my disposal for this report; while my indebtedness to Dr. Baker, and especially to Dr. Randall, is obvious.

EXAMINATION OF THE BLOOD IN PULMONARY TUBERCULOSIS, WITH SPECIAL REFERENCE TO PROGNOSIS.

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HISTORICAL.—The blood in tuberculosis has for many years been the subject of investigation by many different observers. Among the first series of clinical examinations of the blood we find cases of tuberculosis recorded, as these earlier reports were based upon methods of examination so different from those now in use and the details of the condition of the patient are so commonly omitted they are of very little service for comparison with the more recent examinations.

In tuberculosis we have such a chronic condition, one which presents so many different phases, types and complications, and which may affect so many organs, that it is not to be wondered at that the results of blood examinations by different observers vary so widely. It is, therefore, only by taking the statistics, classifying the findings in different types of tuberculosis, and studying them in relation to one another that we can hope to derive any information of value for diagnosis and prognosis.

HÆMOGLOBIN. As this was the first component of the blood to be studied quantitatively for clinical purposes we find a large